

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/21/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>INDIANA UNIVERSITY HEALTH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1701 N SENATE BLVD INDIANAPOLIS, IN 46202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This survey was for the investigation of one State hospital complaint.</p> <p>Complaint number: IN 00161622 Substantiated: No deficiencies related to the allegations are cited.</p> <p>Date: 7/21/2015</p> <p>Facility number: 005051</p> <p>Indiana University Health is in compliance with 410 IAC 15-1.5-5, Medical Staff Services and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: 08/05/15</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE